Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

J T DILGER JR MD
6718 MONTAY BAY DRIVE
SPRING TX 77389

Carrier's Austin Representative Box
19

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Date Received
FEBRUARY 9, 2012

MFDR Tracking Number
M4-12-1989-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Designated Doctor Exam for MMI & IR"

Amount in Dispute: $650.00 + interest for 240 days

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary dated February 27, 2012: "The carrier has paid the amount in dispute."

Response Submitted by: Flahive Ogden & Latson, P. O. Box 201320, Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 19, 2011	99456-WP-W5 99456-WP-W5	$650.00 + interest for 240 days	$15.11

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §134.130 sets out the procedures for Interest for Late Payment on Medical Bills and Refunds.
2. 28 Texas Administrative Code §133.240 sets out procedures for medical payment and denials
3. Texas Labor Code §413.019 sets out procedures for Interest Earned for Delayed Payment, Refund, or Overpayment regarding medical services and fees.
4. Texas Labor Code §401.023 sets out procedures for computation of Interest or Discount Rate.
5. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

6. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
7. Copies of the explanation of benefits were not submitted by either party. The disputed services will therefore be reviewed per the applicable Division rules and fee guidelines.

Issues

1. What is the Maximum Allowable Reimbursement (MAR) for CPT Code 99456-WP-W5?
2. What is the interest due per 28 Texas Administrative Code §134.130?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor billed the amount of $650.00 for CPT code 99456-WP-W5 with 1 (one) unit in Box 24G of the CMS-1500 for a Designated Doctor Examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). Review of the documentation supports that the doctor assigned MMI. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. The requestor submitted documentation to support the Impairment Rating was performed per AMA Guides to the Evaluation of Permanent Impairment, 4th Edition for the right knee (lower extremity) per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a) with the Range of Motion (ROM) IR method. The Maximum Allowable Reimbursement (MAR) for the Impairment Rating is $300.00. The combined MMI/IR MAR is $650.00. Documentation received from the respondent via facsimile on August 1, 2012 indicates that the insurance carrier paid $650.00 to the requestor on March 9, 2012; therefore no additional amount is due for 99456-WP-W5.
2. The requestor alleges that interest is due for the service in dispute. Pursuant to 28 Texas Administrative Code §134.130(a) "Insurance carriers shall pay interest on medical bills paid on or after the 60th day after the insurance carrier originally received the complete medical bill, in accordance with §133.240 of this title (relating to Medical Payment and Denials). Additionally, 28 Texas Administrative Code §134.130(c) states, "The rate of interest to be paid shall be the rate calculated in accordance with Labor code §401.023 and in effect on the date the payment was made." On October 11, 2012, the division contacted the carrier via memorandum to request information/documentation to establish the date that the carrier received a complete medical bill for the service in dispute. The carrier did not provide responsive documents for review in this case. The provider's documentation supports that the requestor in this fee dispute first submitted the medical bill on May 20, 2011 to fax number 866-217-6734. Therefore, the division concludes that the date the carrier originally received the complete medical bill is May 20, 2011.
3. The respondent reimbursed the requestor the amount of $0.00 for interest due. In accordance with 28 Texas Administrative Code §134.130, the appropriate amount due for interest is $15.11. Therefore an additional amount of $15.11 is recommended for payment.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $15.11.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $15.11 per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 29, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.